



GEORGIA HEALTH LAW DEVELOPMENTS

A PUBLICATION OF THE HEALTH LAW SECTION OF THE STATE BAR OF GEORGIA

MESSAGE FROM THE CHAIR

NOTICE

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Health Law Section

Message from the Chair1

Health Law Developments

IRS Examination of Corporate Governance Practices For Tax-Exempt Entities3

History Shows Health Care Reform will Spur Round of Transaction Activity4

HIPAA Breach Notification Regulations – Sanctions No Longer Discretionary6

Opening the War Chest: Recent Federal Efforts Intensifying the Fight Against Health Care Fraud9

Greetings Health Law Section Members,

While the weather has not always cooperated with us, we are off to a great start this year. In January, the Section met for lunch at the State Bar of Georgia Mid-Year Meetings. Due to ice and snow we lost a few attendees, including our guest speaker, Doug Colburn, the Department of Community Health's new chief of Health Care Facility Regulation. Nonetheless, we had a fantastic gathering and we thank all those who braved the weather to attend the luncheon. We also thank Rod Meadows for chairing our annual Fundamentals of Health Law seminar, which was held on March 5, 2010. Rod again had a great group of presenters.

The Health Law Section is currently working with the American Health Lawyers Association (AHLA) to help more widely disseminate certain topics in AHLA's Public Information Series. The Series is a collection of consumer-friendly resources designed to provide health care professionals, health care executives, public health agencies, pro bono attorneys, consumer groups, and the general public with easy to understand information about health care services.

Much appreciation goes to all of the authors who contributed to this newsletter. In this edition, Keith Mauriello informs of us about the new HIPAA Breach Notification Regulations, Brian McEvoy gives an update on health care fraud enforcement and Tom Hawk provides insight into the effects of health care reform. Additionally, we have a brief note on the new Internal Revenue Service examination guidelines focused on corporate governance of tax-exempt organizations. Thanks to Summer Martin for her assistance in publishing the newsletter. We hope to publish another edition in the summer that will highlight the activities under the Gold Dome.

Lastly, mark your calendars for our annual Advanced Health Law seminar. We look forward to seeing you at the seminar, which will be held Friday, October 8th at the Fours Seasons Hotel in Atlanta.

The Executive Committee continually seeks to prepare meaningful programs for our Section and provide you with information relevant to the practice of health care and we hope that you have benefited from these efforts. We invite our members to submit articles, reports, and proposals for presentations that would be informative to the membership.

It is an honor to serve as Chair this year. Please let me or anyone on the Executive Committee know if you have any ideas or suggestions to help us better serve you.

Best regards,

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IRS Examination of Corporate Governance Practices For Tax-Exempt Entities

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Over recent months, the Internal Revenue Service (“IRS”) has increased its focus on good governance practices within tax-exempt organizations. Good governance practices have the potential to improve compliance with the law and encourage the nonprofit sector to safeguard its charitable assets and serve its tax-exempt purposes. To some extent, the IRS has always promoted good governance in the non-profit sector. While specific governance practices are not required for 501(c)(3) exemption, the IRS has, in some instances, required governance by an independent body for tax-exempt status. Additionally, the IRS considers governance issues in the determination process in both the Form 1023 completion and the IRS decision on whether to grant exemption. The IRS also may focus on governance matters during an audit or other compliance initiative. In 2007 (effective for the 2008 tax year), the IRS changed the Form 990 to seek information on tax-exempt organizations’ governance structures. Although education and outreach efforts by the IRS cannot proscribe obligations on tax-exempt organizations, the IRS’ increasing efforts of addressing governance in these arenas indicates the IRS’ interest in and expectations for the governance structures of tax-exempt entities. To this end, in December 2009, the IRS issued guidelines for governance examination in the form of the Governance Check Sheet and the Guide Sheet. These documents provide a specific checklist, indicating which governance-related items the IRS considers significant in its examination of tax-exempt entities.

The Governance Check Sheet (Form 14114) was created for use by IRS Revenue Agents when conducting examinations of tax-exempt entities. Thus, the 2-page Check Sheet provides specific guidance on what the IRS will examine. Overall, the IRS’ focus in this document is more practical, not based broadly on policy. The Governance Guide Sheet assists Revenue Agents in completing the Governance Check Sheet. The Guide Sheet includes examples for how certain questions should be answered depending on specific scenarios.

The Check Sheet concerns six aspects of the governance structure: (1) Governing Body and Management, (2) Compensation, (3) Organizational Control, (4) Conflicts of Interest, (5) Financial Oversight and (6) Document Retention. Through examination of tax-exempt entities by its Revenue Agents, the IRS expects to collect the following types of information:

- Governing Body and Management - the IRS inquires whether the organization has a written mission statement and whether the current activities of the organization reflect the mission statement. Revenue Agents must also indicate the individuals or groups to whom the organization provides copies of its articles and bylaws. Several questions apply to the organization’s board, including the number of board meetings held and whether that number met or exceeded meeting requirements set forth in the organization’s bylaws.
- Compensation - this section focuses on the procedure utilized to establish compensation, including whether compensation arrangements are approved in advance by an authorized body of the organization composed of individuals that do not have conflicts of interest regarding the compensation arrangements. The Check Sheet also inquires whether comparability data is used in determining compensation and whether meeting minutes or other documents reflect the reasoning underlying compensation determinations.
- Organizational Control - primarily includes questions regarding family or business relationships between the officers, directors, trustees or key employees of the organization. This section also inquires whether effective control of the organization rests with a single or a select few individuals. The Guide Sheet indicates that this determination would include considering whether the board typically defers to a single individual or a small group of individuals.

- Conflict of Interest - this section is based on the organization's conflict of interest policy, including whether the policy is written, whether it addresses recusals, whether it requires annual written disclosures of conflicts of interest and whether the organization adhered to the policy. The Guide Sheet provides as an example scenarios in which board members do not recuse themselves when a conflict of interest is present in the corresponding decision making process.
- Financial Oversight - focuses on the use of the organization's assets. This section also inquires whether the board received and reviewed reports of the organization's financial activities, including review of the Form 990.

- Document Retention - this section looks at the organization's document retention and destruction policy. The Check Sheet asks whether such written document exists, and if so, whether the organization adheres to the written policy.

Tax-exempt organizations and their counsel should carefully review the Governance Check Sheet Form 14114 and the Guide Sheet and determine whether the organization's governance practices comply with the IRS' expectations. The Check Sheet and Guide Sheet are available on the IRS' website at www.irs.gov/pub/irs-tege/governance_check_sheet.pdf and www.irs.gov/pub/irs-tege/governance_guide_sheet.pdf.

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History Shows Health Care Reform will Spur Round of Transaction Activity

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The American health care system accounts for approximately one-sixth of the total annual Gross Domestic Product and is growing faster than other sectors of the economy. Although other sectors of the economy have been losing jobs at a fast clip, the health care industry has continued to add jobs through the recession. As of this writing, Congress and the Administration are considering a number of health care reform proposals. Substantial changes in how health care is delivered and paid for are being considered. Two principal changes are planned. The federal government plans to increase health insurance coverage while "bending the cost curve" for such coverage downwards. The expansion of health insurance coverage will bring considerable changes to the health insurance industry. The cost control changes (i.e., spending reductions) will have a significant and potentially adverse impact on health care providers, suppliers and other health care industry players. As of this

writing, the Administration and the Congress were still discussing how to get health care reform across the finish line.

As is often said, change brings opportunities. While reimbursement reductions will be painful in some respects, expanded coverage could present some industry participants with new opportunities that could offset the effect of the reimbursement reductions. If history is any guide, the shifting landscape in various sectors of the health care industry from physicians and other practitioners -- to institutional providers like hospitals -- to pharmacy and medical device manufacturers -- and finally (and perhaps most significantly) to health insurance companies -- has the potential to drive a wave of new transactional activity as companies seek to use economies of scale to offset pinched profit margins. We have been down this road before.

The last major health care reform effort failed in 1994. By the time the reform effort failed, however, health care industry participants had already begun to react to the perceived changes. In the few years following that effort, insurance companies expanded the use of managed care models to control costs. Hospitals and physicians and other providers joined together to form integrated delivery systems to negotiate and contract with (and in some cases share risk with) insurance companies and other entities that pay for health care services. A number of other new models arose to deal with the “new paradigm” of the health care industry, including multi-hospital and physician group integrated delivery systems. For example, several large nonprofit hospital systems in Atlanta, along with their affiliated physician groups, formed an alliance to integrate their operations in an effort to respond efficiently to the pressures of managed care.

Budget cutting a few years later added additional pressure to certain health care providers. The Balanced Budget Act of 1997 included significant reductions to many providers that spurred an additional round of deal making. Hospitals, physicians and home health agencies were hit particularly hard in that act (some of the cuts were later restored). Many community hospitals, already close to negative operating margins, were pushed into the red. Around this time, investor-owned hospital companies began to capitalize on anxiety among community hospitals and their board members about the future operating environment. Hospital chains like HCA, Inc., Health Management Associates, Inc. and Tenet Healthcare Corporation went on an acquisition spree and significantly expanded their presence in Georgia generally and in metropolitan Atlanta particularly.

Similarly, pressure on physician reimbursement from managed care and the Balanced Budget Act of 1997 (as well as the increased administrative burdens from managed care) caused many physician groups to consider their practice options. In some cases, physicians aligned themselves with hospital systems and became employed by hospitals or their affiliates. In addition, physician practice management companies (“PPMs”) bought up a number of physician practices as well. A few physician groups decided to follow something akin to a law firm model and organized into multi-specialty groups offering everything from primary care

services to specialists to various ancillary services from one clinic.

When it turned out that the “new paradigm” for health care was not all that different from the old paradigm, a number of these transactions were subsequently unwound, as was the case with many PPMs and hospital acquisitions of physician practices. In addition, some of the integrated delivery system structures were never utilized to a great degree. Nevertheless, the changes that the industry perceived to be on the horizon in the 1990s set in motion a number of health care deals.

As I noted, the current health reform effort includes changes to expand access as well as to control costs. Both the expansion of access and the cost control mechanisms have the potential to drive transaction activity in the industry. Some changes, already passed into law, have begun even now to cause changes. Congress passed in February 2009 the American Reinvestment and Recovery Act (“ARRA”) (also known as the stimulus bill). Most notably, ARRA contained substantial incentives for providers to use electronic health records. Eligible physicians may receive incentive payments in excess of \$60,000. Hospitals can receive substantial incentive payments as well. However, in order to qualify for incentive payments, providers must comply with certain “community organizing” requirements. This will require various types of providers to enter into arrangements to cooperate and align their efforts and electronic health records systems, which could spur a round a deal making. Attorneys will need to familiarize themselves with these requirements and be prepared to counsel clients on appropriate structures to qualify for the government incentive payments for use of electronic health records.

Beyond the ARRA provisions, the health reform bills under consideration include substantial changes to the health insurance market. As of this writing, several major proposals are still under discussion, including a “public option” insurance provider to compete with private plans, as well as nonprofit “cooperatives” that would receive federal start up money to compete with private plans. Community groups or groups of providers may take advantage of the opportunity to organize an insurance cooperative and receive federal start up money. The stated purpose of each of the public option and the cooperative models is to compete with private insurance to drive health

insurance costs down. This in turn will put pressure on the profit margins of major insurance companies. The result could be that weaker insurance companies may exit the market or may be vulnerable to takeover.

In addition to the insurance market changes, a number of cost control measures are being considered including, among other things, outright reductions in payments to certain categories of providers and suppliers, taxes or fees on certain providers, suppliers or medical equipment manufacturers, and changes in how the federal health care program reimburses for certain items or services. Although the various bills being considered vary with respect to specific cuts or taxes, the home health care providers, durable medical equipment providers and freestanding imaging centers face cuts. The rate of growth for hospital reimbursement is also expected to slow. With the expansion of health insurance coverage,

supplemental payments to hospitals for treating the uninsured (called disproportionate share hospital payments) are also targeted for reduction. The reimbursement cuts and other regulatory changes will narrow or eliminate the profit margins of many affected providers and could spur a round of consolidation. Indeed, we already see a number of deals involving freestanding imaging center arising out of the recent changes to the rules governing Independent Diagnostic Testing Facilities.

Whatever reforms ultimately pass, it is clear that big changes may be on the way. These changes will inevitably result in some repositioning and possibly consolidation in certain sectors of the health care industry. Lawyers should keep abreast of fast moving developments in this area to counsel clients on how best to respond to changing market dynamics.

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HIPAA Breach Notification Regulations – Sanctions No Longer Discretionary

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On February 22, 2010, the U.S. Department of Health and Human Services (“HHS”) will begin enforcing penalties for violations of the breach notification regulations, as announced in the Interim Final Rule found at 74 Fed. Reg. 42,739, 42,757 (Aug. 24, 2009). As most healthcare providers and their attorneys are already aware, the Health Information Technology for Economic and Clinical Health Act (the “HITECH Act”) resulted in the promulgation of new regulations, effective September 23, 2009, that require covered entities to provide notification to individuals, HHS and in some instances media outlets when there is a breach of unsecured protected health information (“PHI”).

When the breach notification regulations went into effect, HHS indicated that it would use its enforcement discretion to not impose sanctions for failing to provide the required notifications for breaches discovered before February 22, 2010.

However, covered entities are still expected to comply with the breach notification regulations as of September 23, 2009, including reporting to HHS breaches occurring between September 23 and December 31, 2009 no later than March 1, 2010. Covered entities also must include in the following year’s report to HHS all breaches occurring in 2010, including those discovered before February 22, 2010.

The breach notification regulations apply only when there is a breach involving “unsecured PHI.” The term “unsecured PHI” is defined as PHI that has not been “rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology” approved by HHS. 45 C.F.R. § 164.402. Thus, a breach of secured PHI maintained in accordance with HHS guidance would not trigger the notification requirements. Although at first glance it may seem easy to secure all PHI in accordance

with HHS guidance, as a technical matter it will likely be challenging and cost prohibitive. As a result, many, if not all, covered entities and business associates will be subject to the new requirements.

Although the regulations are relatively straightforward with respect to the timing and content of the requisite notices, the initial determination as to whether an unauthorized disclosure of unsecured PHI constitutes a “breach” is a fact intensive analysis.

Is There A Breach? – Risk Assessment

A “breach” is defined as “the acquisition, access, use, or disclosure of protected health information ... which compromises the security or privacy of protected health information.” 45 C.F.R. § 164.402 (emphasis added). The phrase “compromises the security or privacy of protected health information” is further defined in the regulations as posing “a significant risk of financial, reputational, or other harm to the individual.” *Id.* (emphasis added). Although any unauthorized disclosure of PHI may be a violation of the Health Insurance Portability and Accountability Act (“HIPAA”) Privacy Rule and may be subject to sanctions, not all unauthorized disclosures are considered “breaches” (i.e., posing a significant risk) that require notification to individuals whose information has been disclosed. Note that there are three narrow exceptions to the definition of “breach” found at 45 C.F.R. § 164.402(2).

This concept of “significant risk” is expounded upon in both the preamble to the breach notification regulations as well as other federal guidelines.¹ For instance, the preamble provides a concrete example to assist covered entities in understanding the parameters and in determining whether a violation of the HIPAA Privacy Rule constitutes a breach:

¹ The preamble to the breach notification rule references a 2007 Memorandum (M-07-16) issued by the Office of Management and Budget which provides “examples of the types of factors that may need to be taken into account in determining whether an impermissible use or disclosure presents a significant risk of harm to the individual.” (OMB Memo 07-16 “Safeguarding Against and Responding to the Breach of Personally Identifiable Information”).

[I]f a covered entity improperly discloses protected health information that merely included the name of an individual and the fact that he received services from a hospital, then this would constitute a violation of the Privacy Rule, but may not constitute a significant risk of financial or reputational harm to the individual. In contrast, if the information indicates the type of services that the individual received (such as oncology services), that the individual received services from a specialized facility (such as a substance abuse treatment program), or if the protected health information includes information that increases the risk of identity theft (such as social security number, account number, or mother’s maiden name), then there is a higher likelihood that the impermissible use or disclosure compromised the security and privacy of the information.

74 Fed. Reg. at 42,745.

Notification of Breach

Pursuant to 45 C.F.R. § 164.404(a), “[a] covered entity shall, following the discovery of a breach of unsecured protected health information, notify each individual whose unsecured protected health information has been or is reasonably believed by the covered entity to have been accessed, acquired, used, or disclosed as a result of such breach.” The notice must be given to the affected individuals “without unreasonable delay and in no case later than 60 calendar days after discovery of a breach.” 45 C.F.R. § 164.404(b). Business associates are also required to report breaches of unsecured PHI to their covered entities. See 45 C.F.R. § 164.410.

A breach is treated as discovered on the day the entity first knew or, with reasonable diligence, should have known about the breach. The regulations contain specific requirements pertaining to the content of individual notifications, including but not limited to, the date of the breach, the information disclosed, a contact person at the covered entity, and efforts to mitigate harm. See 45 C.F.R. § 164.404(c).

Covered entities must also notify HHS of any breach of unsecured PHI. If a single breach involves 500 or more individuals, the covered entity is required to report to HHS at the same time the covered entity notifies affected individuals and in the manner specified on the HHS website. If a single breach of unsecured PHI affects fewer than 500 individuals, the covered entity must maintain a log, and report the breach to HHS on an annual basis within 60 days of the end of the calendar year and in the manner specified on the HHS website. See 45 C.F.R. § 164.406. HHS has published an online reporting form, which can be found at <http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html>.

In the event there is a single breach involving more than 500 residents of one state, the covered entity must notify prominent media outlets serving that state without unreasonable delay and no later than 60 days after discovery of the breach. The

media notification must contain the same information required in the individual notification. See 45 C.F.R. § 164.406.

Conclusion

It is important for covered entities, business associates, and their counsel to become familiar with the breach notification regulations if they have not already done so. While many covered entities may have established procedures following the September 23, 2009 effective date of the regulations, it is imperative at this time to ensure that the regulations and related policies are completely understood now that HHS will start to impose sanctions for failing to provide the required notifications as of February 22, 2010. HHS seemed to be somewhat lenient in delaying enforcement, but the grace period has come to pass and it is time to make certain the breach notification regulations are being followed.

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Opening the War Chest: Recent Federal Efforts Intensifying the Fight Against Health Care Fraud

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On January 27, 2010, Michel De Jesus Huarte was sentenced to 22 years in prison in the Southern District of Florida for his role in a health care fraud conspiracy which operated in Florida, Georgia, Louisiana, North Carolina and South Carolina. Huarte's co-defendants received lesser sentences ranging from 18 months to 15 years in prison for their part in a \$100 million HIV infusion medication scam.²

Perhaps coincidentally, the very next day the Department of Health and Human Services (HHS) and the Department of Justice (DOJ) held a National Summit on Health Care Fraud – focused on health care fraud as an epidemic which has indeed become a national economic crisis. The summit was the latest initiative of the Health Care Fraud Prevention and Enforcement Action Team (HEAT), a joint HHS-DOJ program that was formally begun in May 2009 by Attorney General Eric Holder. The National Summit was an unprecedented event on the topic of health care fraud. Not only were HHS and DOJ involved, but also numerous other law enforcement agencies, as well as leading members of the private sector, including insurers. This impressive group of private and public entities came together as a part of the Obama Administration's new initiative to promote the coordination and sharing of health care fraud data between the public and private sector.

In her opening remarks to the Summit, HHS Secretary Kathleen Sebelius emphasized the administration's "zero tolerance stance" for criminals who cheat taxpayers and consequently endanger patients and the future of Medicare. Recognizing that all those in attendance have an interest in putting a stop to health care fraud, Secretary Sebelius issued a call to arms, stating:

Today, the President has asked us to put these criminals on notice. The problem of health care fraud is bigger than either government, law enforcement or the private industry can handle alone. We will need all of us working together to solve it. In the fight to prevent, find, catch, and prosecute these crooks, we want every good idea we can get.

Health care fraud is a national problem. It affects federal programs like Medicare, state programs like Medicaid, and private insurance companies. We're all part of a health care system that has been undergoing rapid growth."³

To illustrate her point concerning the rapid growth of fraud and abuse in the health care system, Sebelius noted that the annual amount spent combating health care fraud has increased from \$75 million to over \$2.5 billion from 1970 until the present. In the eyes of Secretary Sebelius this means that, "[t]he difference between catching fraud then and now is the difference between trying to find a penny in a bathtub and trying to find a penny in a swimming pool."⁴

² Jay Weaver, *Miami man gets 22 year for Medicare clinic fraud*, THE MIAMI HERALD, Jan. 27, 2010, available at MiamiHerald.com.

³ Health and Human Services Secretary Kathleen Sebelius, Remarks at National Summit Health Care Summit (January 28, 2010) (transcript available at <http://www.hhs.gov/secretary/speeches/sp20100128.html>).

⁴ *Id.*

In his own opening remarks, Attorney General Eric Holder described the Summit as a critical step forward in the work being done by the Health Care Fraud Prevention and Enforcement Action Team (HEAT), HHS-DOJ joint task force programs initiated by the Department of Justice in May 2009. Attorney General Holder informed those in attendance that 2009 was “an all time high” in the number of health care fraud charges levied against defendants, with over 800 defendants charged and 580 convictions, due in large part to the HEAT program and its strike forces.⁵ He also stated that DOJ civil enforcement of health care fraud laws recovered over \$2.2 billion dollars under the False Claims Act.

Notwithstanding the positive news, Attorney General Holder described health care fraud as a serious problem whose scope is “simply shocking,” noting that more than \$60 billion in public and private health care spending is lost to fraud each year. Like Secretary Sebelius, Attorney General Holder tacitly admitted that, due to the size and amount of money involved in the national health care system, “so long as health care fraud pays and these crimes go unpunished, our health care system will remain under siege.”⁶

Attorney General Holder’s Estimate of the Scope of Health Care Fraud May Be Too Low

The \$60 billion dollar health care fraud figure cited by Holder may in fact be too conservative of an estimate, however. In May 2009, while testifying before the Senate Committee on the Judiciary: Subcommittee on Crime and Drugs, Malcolm K. Sparrow, a Harvard Professor of Public Management and expert in fraud detection and control strategy, stated:

The units of measure of losses due to health care fraud and abuse in this country are hundreds of billions of dollars per year. We just don’t know the first digit. It might be as low as one hundred billion. More likely it is two or three. Possibly four or five. But whatever that first digit is, it has eleven zeroes after it.⁷

Other experts mirror Sparrow’s conclusions, putting the estimated annual loss between \$70 and \$100 billion.⁸ Regardless of the actual number, losses from health care fraud are massive, and everyone agrees that these losses are a major contributor to the escalating health care costs facing all Americans. Illustrated another way, some 10-20% of the annual Medicare and Medicaid budget is spent on fraudulent or false claims.⁹

Historical Data Concerning Civil Enforcement of Health Care Fraud

While this is disturbing news for prosecutors, lawmakers and taxpayers, such widespread fraud can present lucrative opportunities for plaintiffs and civil lawyers who are well versed in health care law. Pursuant to the False Claims Act, 31 U.S.C. § 3729, *et seq.*, persons with evidence of fraud involving federal programs or contracts, known as “relators,” may file a civil *qui tam* suit against the wrongdoer on behalf of the United States. Such a law suit is initially filed under seal, and the Government has the right to intervene and join in the action against the defendant, if it sees fit. If a relator, or the Government upon

⁵ Attorney General Eric Holder, Remarks at National Summit Health Care Summit (January 28, 2010) (transcript available at <http://www.stopmedicarefraud.gov/innews/holderremarks.html>).

⁶ *Id.*

⁷ Malcolm K. Sparrow, Testimony at “Criminal Prosecution as Deterrent to Health Care Fraud” before Senate Committee on Judiciary: Subcommittee on Crime and Drugs (May 20, 2009) (transcript available at <http://www.hks.harvard.edu/news-events/testimonies/sparrow-senate-testimony>) [hereinafter “Sparrow Testimony”].

⁸ Rudman, et al., Health care Fraud and Abuse, 6 *Perspectives in Health Information Management* 1 (Fall 2009); Association of Certified Fraud Examiners, Health care Fraud, available at www.acfe.com/resources/fraud-101-health-care.asp (last visited February 23, 2009).

⁹ Sparrow Testimony, *supra*.

intervention, is successful in recovering money from the defendant, either through a judgment or a settlement, the False Claims Act provides that the Relator is entitled to 15-30% of the amount recovered.

Unlike a criminal fraud case, which requires proof beyond a reasonable doubt, in a civil *qui tam* the Government is only required to prove the existence of fraud by a preponderance of the evidence. Furthermore, where proof of knowing violations or submissions are made, the Government may recover three times the amount of loss suffered.

As of 2004, 80% of all *qui tam* cases filed were related to health care fraud.¹⁰ This was nearly double the percentage of health care cases observed just seven years earlier.¹¹ Accordingly, much of the \$2.2 billion in civil enforcement recoveries as well as the criminal prosecutions for health care fraud, described by Attorney General Holder at the National Summit, likely began with the filing of a *qui tam* complaint. It is not uncommon for the Government, when investigating a relator's claim to determine whether to intervene in their Complaint, to discover other fraudulent behavior unknown to the relator, which leads to both civil and criminal action on the part of the Department of Justice.

While a relator may continue to pursue his or her *qui tam* action against the defendant if the Government decides not to intervene, chances of success, as well as the size of any recovery, are largely influenced by whether the Government intervenes or not. This is clear upon reviewing the data maintained by the Department of Justice's civil division concerning all *qui tam* actions, health care and otherwise, filed from 1986 through 2009.¹² That data shows:

Table 1

From 1986-2009	Settlement or Judgment Reached	Case Dismissed	Total No. Concluded cases	Success rate
DOJ Civil Division Intervened	1,076	58	1,134	95%
DOJ Civil Division did not intervene	239	3,681	3,920	6%
All Cases (regardless of intervention)	1,315	3,739	5,054	26%

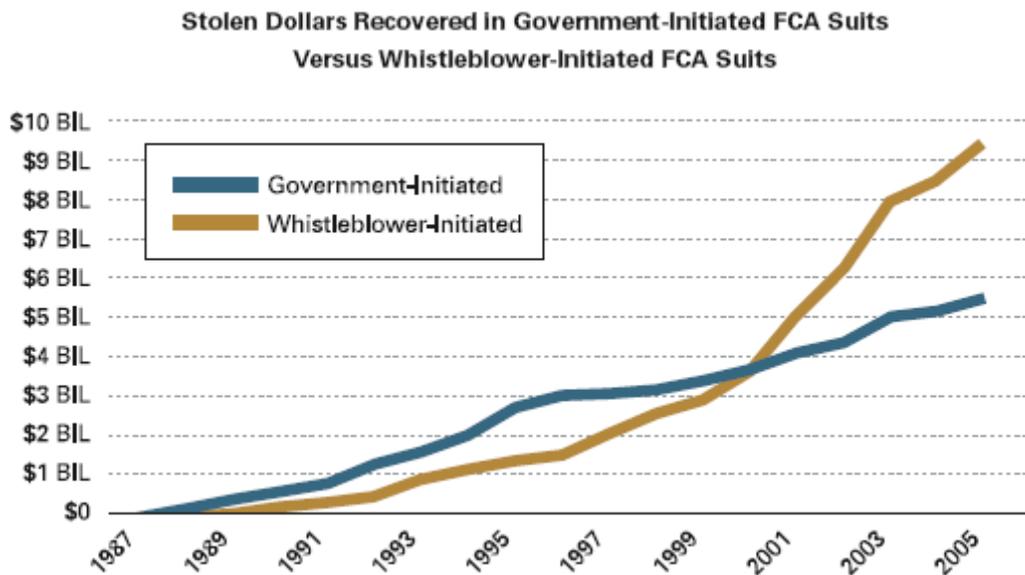
Not only does Government intervention lead to an extraordinarily high success rate, but the Department of Justice data also reveals that Government intervention results in the relator's 15-30% share historically being 28 times higher than if the Government declines to intervene.

¹⁰ Jack A. Meyer, President, Economic and Social Research Institute, *Fighting Medicare Fraud: More Bang for the Federal Buck*, prepared for Taxpayers Against Fraud Education Fund (July 2006) available at <http://www.taf.org/FCA-2006report.pdf> (last visited February 27, 2010).

¹¹ John R. Phillips and Mary Louise Cohen, Failing to report Medicare billing errors: a very risky business, *Journal of the Association of Health care Internal Auditor* (Spring 1997).

¹² Taxpayers Against Fraud, *Fraud Statistics – Overview*, October 1, 1987 – September 30, 2009, Civil Division., U.S. Department of Justice, available at <http://www.taf.org/FCAstats2009.pdf>.

One explanation for the extraordinarily high success rate and high reward rates are that the Government is able to engage in a more thorough fact investigation than a whistle-blowing relator and, to that end, is able to determine more accurately how good a case is before they decide whether to intervene or not. Regardless of the reasons of their successes, the statistics contained in Table 1 above make it abundantly clear that in order to succeed in a *qui tam* action, the Government's intervention is all but required. Furthermore, according to the chart below,¹³ there is evidence that the returns for the Government are also greater where the *qui tam* case originates from a relator, as opposed to the Government's own independent investigation.



From the perspective of the civil litigators interested in *qui tam* cases, the increased government investment in health care fraud, both in terms of man power and funds, is likely to lead to increased rates of government intervention, to the benefit of your clients. From the perspective of the those lawyers representing health care providers, the increased investment will obviously require a corresponding increase in diligence on the part of your clients to avoid health care fraud issues. Unfortunately, since the Government's investigations are now more focused on data trends to uncover fraud, the diligence necessary to uncover potential fraud may require some clients to invest in expensive and complicated audits of their electronic billing systems. Furthermore, the increased focus on health care fraud may also lead to a more combative and a more punitive environment as providers' attempt to resolve or settle health care fraud matters.

¹³ Taxpayers Against Fraud, *The 1986 False Claims Act Amendments: A Retrospective Look at Twenty Years of Effective Fraud Fighting in America*, p.5 (2006) (available at <http://www.taf.org/retrospective.pdf>) (last visited February 27, 2010).

A Review of the HEAT Program

Unfortunately for the typical *qui tam* relator, the Government historically only intervenes in 22% of all *qui tam* cases filed. It is in this context that one should consider the implications of the joint undertaking by HHS and DOJ, the Health Care Fraud Prevention and Enforcement Action Team (HEAT).

On May 20, 2009, in a joint press release,¹⁴ Attorney General Holder and Secretary Sebelius announced the formal creation of HEAT and revealed the existence of the third and fourth joint Strike Teams that were investigating health care fraud under the auspices of both the DOJ and HSS. Through the HEAT program, HHS and DOJ are engaging in data-focused investigations of potential health care fraud, pooling their data to discover billing trends that may be indicative of fraud.

While HEAT may have been publicly announced in May 2009, HHS and DOJ had been engaging in data focused joint investigations through the creation of Medicare Fraud Strike Force teams since March 2007, when the first such team was created to investigate health care fraud in Miami-Dade County.¹⁵ Later dubbed “Phase One” the Miami Strike Force has been a resounding success in its first three years of exists garnering more than \$220MM in court-ordered restitution in 87 cases involving 159 defendants in criminal cases alone. Furthermore, based on a 12 month before and after analysis of claims in the Miami-Dade County area, it is estimated that Phase One’s acts have led to a reduction of \$1.75BB in durable medical equipment claim submissions and \$334MM in durable medical equipment claims paid by Medicare.¹⁶

In light of these successes, DOJ and HHS created another Strike Force, Phase Two, which jointly investigated health care fraud in the Los Angeles Metro Area in March 2008. This program is responsible for \$55MM in court-ordered restitution in 21 cases involving 37 defendants.¹⁷ Phases Three and Four were announced in the May 20, 2009 release, though they had been operating since early 2009. Phase Three has already resulted in the prosecution of 14 cases \$106MM.¹⁸

Along with the creation of HEAT, the proposed budget for fiscal year 2010 called for a 50% increase in spending on fraud and abuse enforcement and prevention, and a total of \$1.7BB in projected spending over the next five years.¹⁹ In this manner, HHS and DOJ are seeking to “raise[] the stakes on health care fraud, with increased tools, resources and sustained focus by senior-level leadership.”²⁰ The statement further opined that the HEAT program, along with the increase in proposed spending, could save the United States over \$2.7BB over the next five years.²¹

¹⁴ U.S. Dept. of Health & Human Services, Press Release, *Attorney General Holder and HHS Secretary Sebelius Announce New Interagency Health Care Fraud Prevention and Enforcement Action Team* (May 20, 2009), available at <http://www.hhs.gov/news/press/2009pres/05/20090520a.html>. [hereinafter “May 20 Press Release”].

¹⁵ Fact Sheet: Phase One Medicare Fraud Strike Force Miami-Dade County, Fla., p.1 available at http://www.stopmedicarefraud.gov/heatsuccess/heat_taskforce_miami.pdf (last visited February 24, 2010).

¹⁶ *Id.*

¹⁷ Fact Sheet: Phase Two Medicare Strike Force Los Angeles Metro Area, p.1 available at http://stopmedicarefraud.gov/heatsuccess/heat_taskforce_losangeles.pdf.

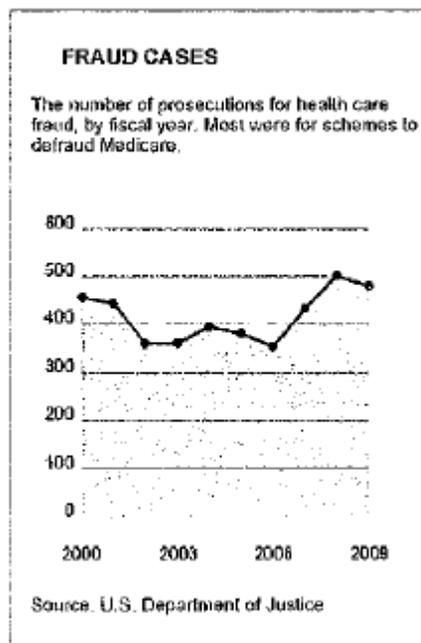
¹⁸ Fact Sheet: Phase Three Medicare Strike Force Detroit Metro Area, p.1 available at http://stopmedicarefraud.gov/heatsuccess/heat_taskforce_detroit.pdf; Fact Sheet: Phase Four Medicare Strike Force Houston Metro Area, available at http://stopmedicarefraud.gov/heatsuccess/heat_taskforce_houston.pdf.

¹⁹ John J. Carney and Robert M. Wolin, *Target Health Care Fraud*, NEW YORK LAW JOURNAL, July 13, 2009.

²⁰ May 20 Press Release, *supra*.

²¹ *Id.*

Implications of the National Health Care Summit



With these statements as background, consider again the National Health Care Summit, which was held last January. At the conference, Attorney General Holder and Secretary Sebelius announced resounding successes of the HEAT program which began as the Medicare Strike Force in Miami some three years prior. Thus, in some respects, the National Summit can be viewed as an elaborate press conference, whose purposes may include deterring persons from engaging in health care fraud, as well as demonstrating the public that the proposed increased investment in the 2010 and 2011 budgets are justified and will pay dividends. To that end HEAT has announced the creation of Strike Force teams in the Brooklyn, New York, Baton Rouge, Louisiana, and Tampa, Florida areas.²²

While the political motivations and the actual deterrent effect such a conference might have on health care fraud is debatable, the conference's true purpose might be considered as an effort by the HHS and DOJ to involve the private sector in the fight against health care fraud. Indeed, a significant portion of the National Summit involved remarks by James Roosevelt, Jr., CEO at Tufts Health Plan and closed door, strategic break out sessions between government enforcement officials and members of the private sector.

Considering the statistics which show that historically, cooperation between private individuals and the Government in civil fraud enforcement leads to greater recoveries for all involved, it is no surprise that the National Summit also served as a well publicized invitation for the private sector to get involved and join in the fight. By emphasizing the successes of the Government's new focus on health care fraud and by unveiling proposed budgetary increases the Government is can be said to be reminding the private sector that there is more than enough success, and money, to go around.

However, there are critics who disagree with the claimed successes of the HEAT program and would question the motivations of the National Summit. Consider recently published statistics²³ which indicate that despite the claims of increased successes, little has changed in terms of Medicare fraud enforcement after the creation of the HEAT program and the increased spending on antifraud provisions. While admitting that the HEAT program has scored some "high-profile" successes since 2007, the authors conclude that "[t]wo years after the federal government started its latest push to crack down on Medicare fraud, the number of people charged with ripping off health care insurers has barely changed."²⁴

²² U.S. Dept. of Health & Human Services, Press Release, Health & Human Services Secretary Kathleen Sebelius, Attorney General Eric Holder Convene National Summit on Health Care Fraud, Unveil Historic Commitment to Fighting Fraud in President's FY 2011 Budget (January 28, 2010) (available at <http://www.hhs.gov/news/press/2010pres/01/20100128a.html>).

²³ Brad Heath, *Little Progress Seen Against Health Insurance Fraud*, USA TODAY (January 29, 2010) (available at http://www.usatoday.com/news/washington/2010-01-28-health-care-insurance-fraud_N.htm).

²⁴ *Id.*

The Future of Health Care Fraud Enforcement

Regardless of the extent of the HEAT program's successes, two facts are indisputable. First, fighting health care fraud is now a higher priority than it ever has been and health care fraud enforcement is being more aggressively pursued by local, state, and federal law enforcement. Second, the present administration is actively choosing to invest more money into health care fraud enforcement than any administration before it. Clearly, no fulsome debate about health care reform in this country can take place without proper consideration of the staggering effects of associated fraud and abuse. More, the economic realities of any system require vigilant detection and enforcement of such waste. These recent developments – involving an enormous injection of resources and money to combat health care fraud - provide some measure of optimism with respect to controlling the costs of our ever ballooning system of health care in this country.

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MESSAGE FROM THE EDITOR – CALL FOR AUTHORS

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